Washington State Health Care Authority
Medicaid

Tribal Program – Procedure Code Billing

Name of Presenter: Jasmine Douglas, Gary Monroe - Provider Relations Unit
Deb Sosa, Tribal Program Manager
October 2012

Tribal Code Billing Model

- Coverage in this training
  - ✓ Billing Policy update
  - ✓ Changes in Tribal Billing
  - ✓ Encounter services
  - ✓ Non-Encounter services
  - ✓ Claim Forms
  - ✓ Coding
  - ✓ Claim Examples
  - ✓ Program and Service Limits
  - ✓ Provider Taxonomy
  - ✓ References

Tribal Code Billing Model

- Billing Policy update:
- Effective for claims billed with a **date of service** on or after October 1, 2012, tribal health programs will be required to begin billing all claims with procedure codes (CPT, and HCPCS codes for professional claims, and CDT codes for dental claims) for the underlying service performed in addition to the T1015 encounter code.
- Total reimbursement will be at the encounter rate for all services that qualify for encounter payment.
- DO NOT bill services with dates of service prior to 10/01/2012 with services for dates of service after 10/01/2012 on the same claim form. Claims will not pay correctly!

Tribal Code Billing Model

- Changes in Tribal Billing
  - ✓ Claims will now require a procedure code billed on the claim for each service provided:
    - **CPT** (Current Procedural Terminology)
    - **HCPCS** (Healthcare Common Procedural Coding System)
    - **CDT** (Current Dental Terminology)
  - ✓ Plus the T1015 code for the encounter eligible services.
  - ✓ There is currently no change to adding the ICD-9 diagnosis code on each claim (except dental).
  - ✓ Claims will require the tribal modifiers on all service lines on the claim (except dental).
- This change will make Tribal billing consistent with FQHC billing methodology.
- Maximum payment for this will be capped at your encounter rate.

Tribal Code Billing Model

Effective October 1, 2012 (Dates of Service)

Claim Line	HCPCS Procedure Encounter Code	CPT/HCPCS/CDT Encounter Service(s) Rendered	Claim Line
1	XXXXX	Bill the corresponding fee-for-service code(s) of the underlying service being performed.	Bill the clinic's usual and customary rate for the service rendered.
2	T1015 Encounter		Bill $0 or $316.00 (doesn't matter)
		Add additional lines as necessary.	

Tribal Code Billing Model – Encounter Services

- For a health care service to qualify as an encounter, it must meet all the following criteria. The service must be:
  - ✓ Medically necessary.
  - ✓ Face-to-face.
  - ✓ Identified in the Medicaid State Plan as a service that is:
    - Covered by the Agency;
    - Performed by a health care professional within their scope of practice.
    - The health care professional must be enrolled with Medicaid and loaded in ProviderOne.
  - ✓ Documented in the client's file in the provider's office.
  - ✓ Performed in the health care facility identified on the IHS facility list; or
  - ✓ Performed at other locations where tribal facility supported activities are performed by qualified clinic staff.

Tribal Code Billing Model- Non Encounter Services

- Services that don't qualify as an encounter include:
  - ✓ Clients that have state only program coverage.
  - ✓ Blood draws, laboratory tests, and/or x-rays, are bundled in the encounter service. If provided outside of an encounter visit bill fee-for-service (FFS).
  - ✓ Drugs or medication treatments provided during a clinic visit are part of the IHS encounter rate.
  - ✓ Case management services:
    - Maternity Support Services/Infant Case Management;
    - HIV/AIDS Case Management.
  - ✓ DME supplies

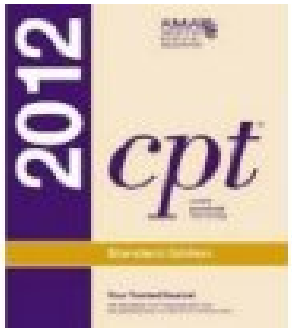
Tribal Code Billing Model-
Non Encounter Services

Services that don't qualify as an encounter include:

- ✓ The code of the underlying service must **not** be one of the following:
  - 36400-36425
  - 36511-36515
  - 38204-38215
  - 70000-79999
  - 80000-89999
  - 90281-90799
  - D0210, D0220, D0230, D0240, D0270, D0272, D0274, D0321, D0330, D0460, D0501
  - All J codes
  - P3000-P3001
  - All Q codes
  - All S codes (**except** S9445-S9470 [inclusive])
- ✓ Note: Code-sets may change in the future
- ✓ Non-encounter eligible covered codes can be billed FFS without the encounter code.

Tribal Code Billing Model

- **CPT** (Current Procedural Terminology) coding claims
  - ✓ Physician claims
  - ✓ Mental Health claims
  - ✓ Chemical Dependency claims
- Plus the T1015 code for the encounter eligible services.
- The current CPT manual looks like this:



- ✓ This coding manual may be purchased at any large book store or online book store (like amazon).

The Agency does not endorse any supplier for these products.

Tribal Code Billing Model

- **HCPCS** (Healthcare Common Procedural Coding System) coded claims:
  - ✓ Physician
  - ✓ Mental Health
  - ✓ Chemical Dependency
  - ✓ DME Supplies
  - ✓ Ambulance
  - ✓ Plus the T1015 code for the encounter eligible services.
- The current HCPCS manual looks like this:

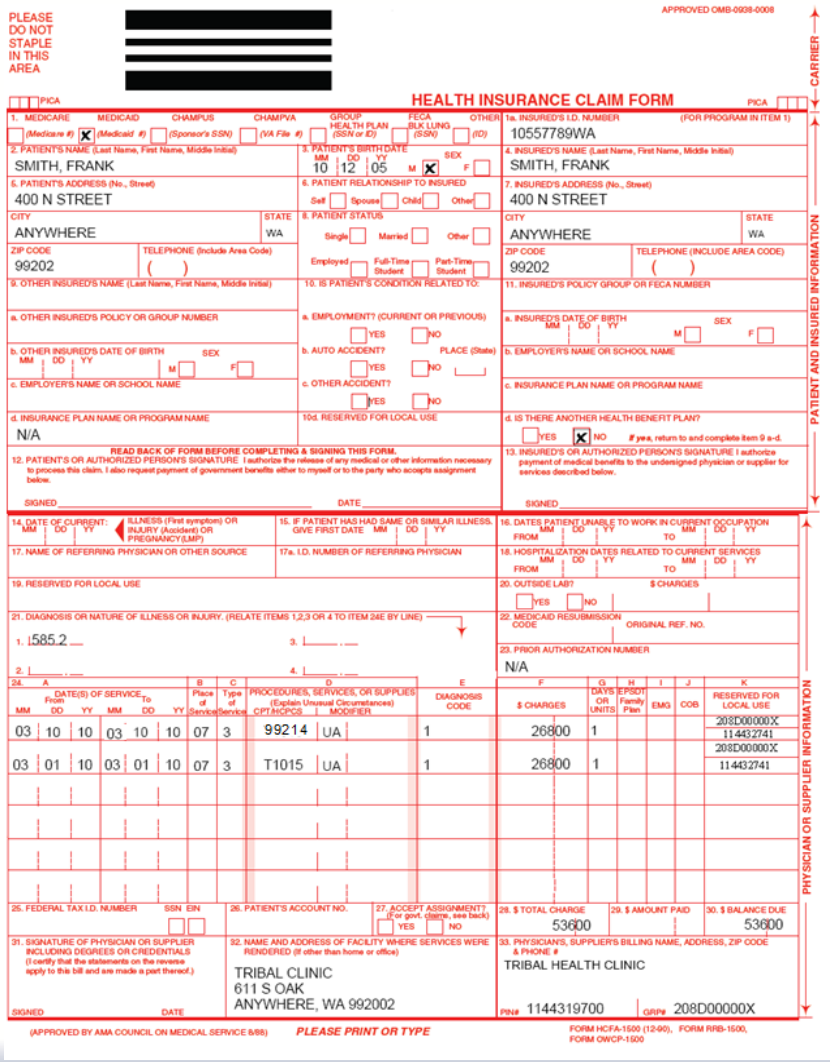
- ✓ This coding manual may be purchased at any large book store or online book store (like amazon).

The Agency does not endorse any supplier for these products.

Tribal Code Billing Model - Professional

- Tribal Providers Billing CPT or HCPCS codes will bill using the:

  - ✓ DDE Professional claim form.
  - ✓ Submit electronic batch claims using the professional claim format.
  - ✓ CMS-1500 paper claim form. The Agency prefers electronic billing.



PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

APPROVED OMB-0938-0008

PICA

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE (Medicare #) X | MEDICAID (Medicaid #) | CHAMPUS (Sponsor's SSN) | CHAMPVA (VA File #) | GROUP HEALTH PLAN (SSN or ID) | FECA BLK LUNG (SSN) | OTHER (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 10557789WA

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): SMITH, FRANK

3. PATIENT'S BIRTH DATE: 10 12 05 | SEX: M X F

4. INSURED'S NAME (Last Name, First Name, Middle Initial): SMITH, FRANK

5. PATIENT'S ADDRESS (No., Street): 400 N STREET

6. PATIENT RELATIONSHIP TO INSURED: Self | Spouse | Child | Other

7. INSURED'S ADDRESS (No., Street): 400 N STREET

CITY: ANYWHERE | STATE: WA

8. PATIENT STATUS: Single | Married | Other; Employed | Full-Time Student | Part-Time Student

CITY: ANYWHERE | STATE: WA

ZIP CODE: 99202 | TELEPHONE (Include Area Code): ( )

ZIP CODE: 99202 | TELEPHONE (INCLUDE AREA CODE): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY | SEX M F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY | SEX M F

b. AUTO ACCIDENT? YES NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME: N/A

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES X NO If yes, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

14. DATE OF CURRENT: MM DD YY | ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. 585.2 3. _____

2. _____ 4. _____

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER: N/A

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
03 10 10	03 10 10	07	3	99214	UA	1	26800	1				208D00000X 11432741
03 01 10	03 01 10	07	3	T1015	UA	1	26800	1				208D00000X 11432741

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. $ TOTAL CHARGE: 53600

29. $ AMOUNT PAID

30. $ BALANCE DUE: 53600

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

TRIBAL CLINIC
611 S OAK
ANYWHERE, WA 992002

33. PHYSICIANS, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

TRIBAL HEALTH CLINIC

PIN# 1144319700 GRP# 208D00000X

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) PLEASE PRINT OR TYPE

FORM HCFA-1500 (12-90), FORM RRB-1500, FORM OWCP-1500

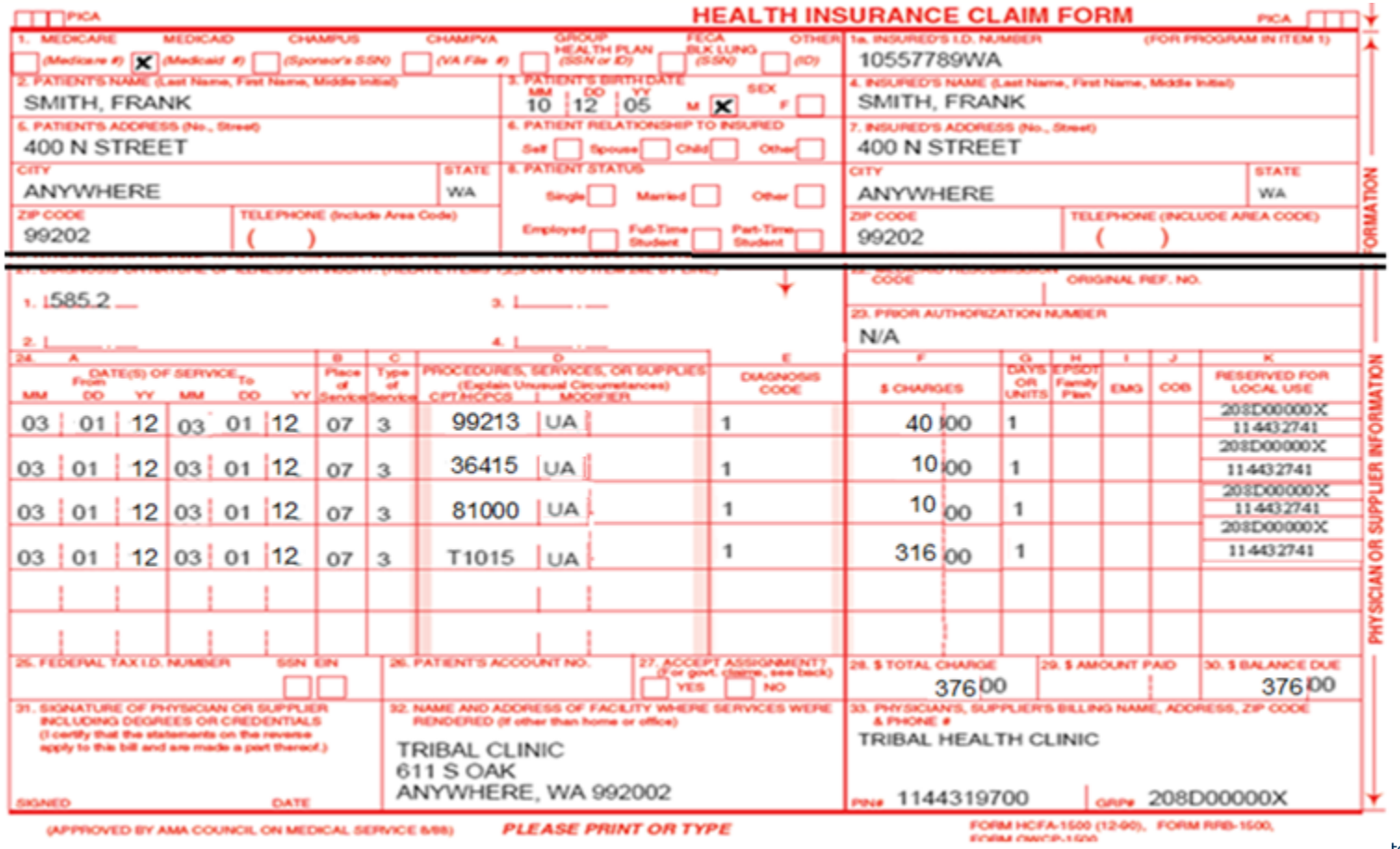
CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

Example of a Medical Claim

- Illustrative example lines of a Medical claim form (please bill electronically or DDE)



HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE [ ] MEDICAID [X] CHAMPUS [ ] CHAMPVA [ ] GROUP HEALTH PLAN [ ] FECA BLK LUNG [ ] OTHER [ ]

1a. INSURED'S I.D. NUMBER: 10557789WA

2. PATIENT'S NAME: SMITH, FRANK

3. PATIENT'S BIRTH DATE: 10 12 05 SEX: M [X] F [ ]

4. INSURED'S NAME: SMITH, FRANK

5. PATIENT'S ADDRESS: 400 N STREET

6. PATIENT RELATIONSHIP TO INSURED: Self [ ] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS: 400 N STREET

CITY: ANYWHERE STATE: WA

8. PATIENT STATUS: Single [ ] Married [ ] Other [ ]

CITY: ANYWHERE STATE: WA

ZIP CODE: 99202 TELEPHONE: ( )

Employed [ ] Full-Time Student [ ] Part-Time Student [ ]

ZIP CODE: 99202 TELEPHONE (INCLUDE AREA CODE): ( )

17. 1. 585.2 3. 2. 4.

23. PRIOR AUTHORIZATION NUMBER: N/A

24. A DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
03	01	12	03	01	12	07	3	99213	UA	1	40 00	1				208D00000X 114432741
03	01	12	03	01	12	07	3	36415	UA	1	10 00	1				208D00000X 114432741
03	01	12	03	01	12	07	3	81000	UA	1	10 00	1				208D00000X 114432741
03	01	12	03	01	12	07	3	T1015	UA	1	316 00	1				208D00000X 114432741

25. FEDERAL TAX I.D. NUMBER SSN [ ] EIN [ ]

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [ ] NO [ ]

28. $ TOTAL CHARGE: 376 00

29. $ AMOUNT PAID:

30. $ BALANCE DUE: 376 00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

TRIBAL CLINIC
611 S OAK
ANYWHERE, WA 992002

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

TRIBAL HEALTH CLINIC

PIN# 1144319700 GRP# 208D00000X

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 6/88) PLEASE PRINT OR TYPE

FORM HCFA-1500 (12-90), FORM RRB-1500,

PHYSICIAN OR SUPPLIER INFORMATION

Example of a Medical Claim

- How ProviderOne pays the previous slide claim example.

MEDICAL VISIT:

Procedure Codes Billed			Fee schedule Allowed Amount
Line 1.	99213-UA	- Office Visit.....	$ 38.63
Line 2.	36415-UA	- Blood Draw.....	$ 2.31
Line 3.	81000-UA	- Lab Test.....	$ 3.45
Total Fee Schedule Allowed Amount:			$ 44.39
Line 4.	T1015 - UA	- Tribal Encounter Value	$ 271.61
Total Claim Payment	($44.39 + $271.61)		$ **316.00**

Note: Line allowed amounts are for an adult from the current fee schedule.

Explanation of Payment:

In this example, the total Fee Schedule Allowed Amount is less than the T1015 Encounter Rate. ProviderOne will calculate the T1015 claim line value and pay it at Encounter Rate minus the total allowed amount for each line or $316.00-$44.39 = $271.61. The total amount paid on the claim for all procedure codes, including the T1015 will equal the encounter rate of $316.00.

Tribal Code Billing Model –
How to Read the Remittance Advice

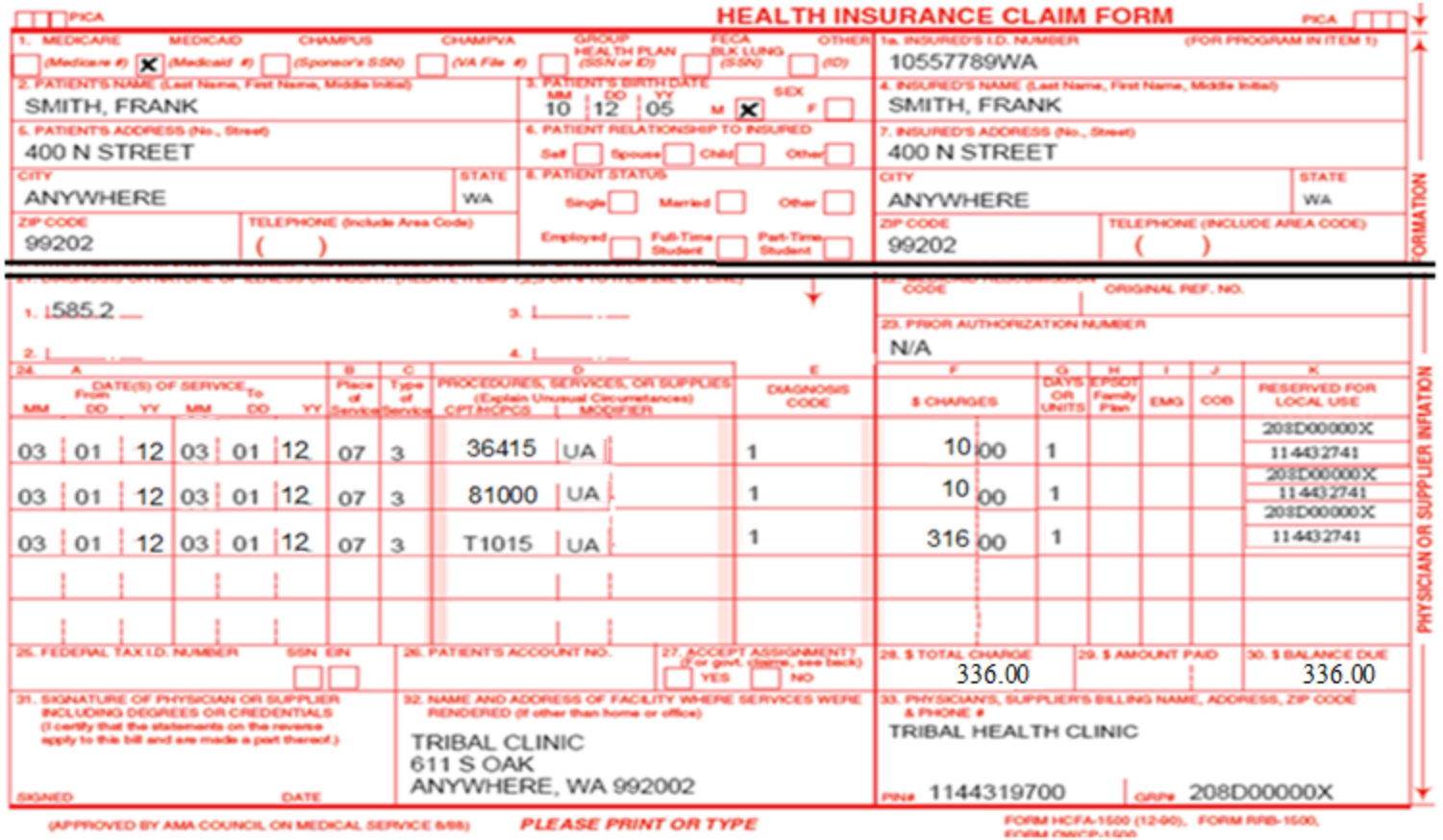
- Below is a copy of a possible claim on a Medical RA.
  - ✓ Each claim line shows the code and paid amount ($63.59 total).
  - ✓ The Encounter line shows the paid value ($316.00-$63.59).
  - ✓ Total claim payment is the Encounter Rate or $316.00.

TCN / Claim Type / RX Claim # / Inv # / Auth #	Line #	Rendering Provider / RX # / Auth office #	Service Date(s)	Svc Code or NDC / Mod / Rev & Class Code	Total Units or D/S	Billed Amount	Allowed Amount	Sales Tax	TPL Amount	Client Responsible Amount	Paid Amount	Remark Codes
Professional Claim	1		08/13/2012-08/13/2012	99214	1.0000	$150.00	$57.00	$0.00	$0.00	$0.00	$57.00	
Professional Claim	2		08/13/2012-08/13/2012	85610	1.0000	$5.29	$4.28	$0.00	$0.00	$0.00	$4.28	
Professional Claim	3		08/13/2012-08/13/2012	36416	1.0000	$10.00	$2.31	$0.00	$0.00	$0.00	$2.31	
Professional Claim	4		08/13/2012-08/13/2012	T1015	1.0000	$0.00	$316.00	$0.00	$0.00	$0.00	$252.41	
	Document Total:		08/13/2012-08/13/2012		4.0000	$165.29	$379.59	$0.00	$0.00	$0.00	$316.00	

Sum of Paid Amounts
$57.00
+$4.28
+$2.31
=$63.59

Example of a Medical Claim

- Illustrative example lines of a Medical claim form – no encounter services (please bill electronically or DDE)



HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE (Medicare #) X | MEDICAID (Medicaid #) | CHAMPUS (Sponsor's SSN) | CHAMPVA (VA File #) | GROUP HEALTH PLAN (SSN or ID) | FECA BLK LUNG (SSN) | OTHER (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 10557789WA

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3. PATIENT'S BIRTH DATE: MM 10 DD 12 YY 05 | SEX: M X F

4. INSURED'S NAME (Last Name, First Name, Middle Initial): SMITH, FRANK

5. PATIENT'S ADDRESS (No., Street): 400 N STREET

6. PATIENT RELATIONSHIP TO INSURED: Self | Spouse | Child | Other

7. INSURED'S ADDRESS (No., Street): 400 N STREET

CITY: ANYWHERE | STATE: WA

8. PATIENT STATUS: Single | Married | Other | Employed | Full-Time Student | Part-Time Student

CITY: ANYWHERE | STATE: WA

ZIP CODE: 99202 | TELEPHONE (Include Area Code): ( )

ZIP CODE: 99202 | TELEPHONE (INCLUDE AREA CODE): ( )

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. 585.2 | 3. | 2. | 4.

22. MEDICAID RESUBMISSION CODE | ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER: N/A

24. A DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
03	01	12	03	01	12	07	3	36415	UA	1	10 00	1				208D00000X 114432741
03	01	12	03	01	12	07	3	81000	UA	1	10 00	1				208D00000X 114432741
03	01	12	03	01	12	07	3	T1015	UA	1	316 00	1				208D00000X 114432741

25. FEDERAL TAX I.D. NUMBER | SSN | EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES | NO

28. $ TOTAL CHARGE: 336.00

29. $ AMOUNT PAID

30. $ BALANCE DUE: 336.00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED | DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

TRIBAL CLINIC
611 S OAK
ANYWHERE, WA 992002

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

TRIBAL HEALTH CLINIC

PIN# 1144319700 | GRP# 208D00000X

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) PLEASE PRINT OR TYPE FORM HCFA-1500 (12-90), FORM RRB-1500,

INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

Example of a Medical Claim

- How ProviderOne pays the previous slide claim example.

MEDICAL VISIT non-encounter:

Procedure Codes Billed			Fee schedule Allowed Amount
Line 1.	36415-UA	- Blood Draw.....	$ 2.31
Line 2.	81000-UA	- Lab Test.....	$ 3.45
Total Fee Schedule Allowed Amount:			$ 5.76
Line 3.	T1015- UA	- Tribal Encounter Value	$ 0.00
Total Claim Payment	($5.76 + $0.00)		$ **5.76**

Note: Line allowed amounts are for an adult from the current fee schedule.

Explanation of Payment:
In this example, the total Fee Schedule Allowed Amount is less than the T1015 Encounter Rate. However since there are no payable encounter services on the claim the encounter line was denied and the claim paid $5.76. This can happen also if the encounter service is denied and the supplement codes would then pay at their allowed amounts (the encounter code would deny in this case also).

Example of a Medical Claim

How do tribes bill for immunizations?

- Children
  - ✓ If the Immunization is free from the Health Department
    - The Agency only pays the administration fee
    - Bill the Immunization code with modifier **SL**
    - e.g. 90707 **SL** and it currently pays $5.96.
    - Be sure to also add the appropriate tribal modifier
  - ✓ Immunizations not free from DOH
    - Bill the Agency with the immunization code(s)
    - Add the administration code(s) as a second line
      - 90471 for admin of one immunization
      - 90472 for the admin of two or more immunizations
- Adults
  - ✓ Immunizations are not free for adults so bill them the same as the not free ones for children.
- If Immunizations are done the same day as a qualified encounter visit they are bundled in the encounter visit and listed on the same claim.

Example of a Medical Claim

How do tribes bill Medicare crossover claims?

- DDE crossover claims will require all the same code lines that were billed to Medicare plus an encounter line (if the service is encounter eligible).
  - ✓ The Medicare payment data is entered at the claim level.
  - ✓ As each line of code is added to the claim, that line's Medicare data is also added.
  - ✓ Add the T1015 encounter code line and the Medicare allowed/paid/coinsurance/deductible amounts on that line will be $0 each however the Medicare paid date is still required.
  - ✓ The line level sum of the Medicare payment data must total the same as the claim level entries.
  - ✓ Payment is up to the encounter rate.

Example of a Medical Claim

How do the tribes bill Commercial Insurance secondary claims?

- There is no change in the overall process to bill secondary claims however:
  - ✓ Now claims will require all the same code lines that were billed to insurance company;
  - ✓ Plus an encounter line if the services billed are encounter eligible.
  - ✓ Tribal modifiers will need to be added.
  - ✓ The insurance payment data is entered at the claim level.
  - ✓ If all insurance information is entered, add the claim note "**Electronic TPL**" and no EOB is required from the insurance.
  - ✓ Payment will be up to the encounter rate.
- Claims will now be subject to all insurance edits in ProviderOne.
- Go to web page http://hrsa.dshs.wa.gov/provider/webinar.shtml to find the webinar presentation for entering commercial insurance secondary claims to the Agency.

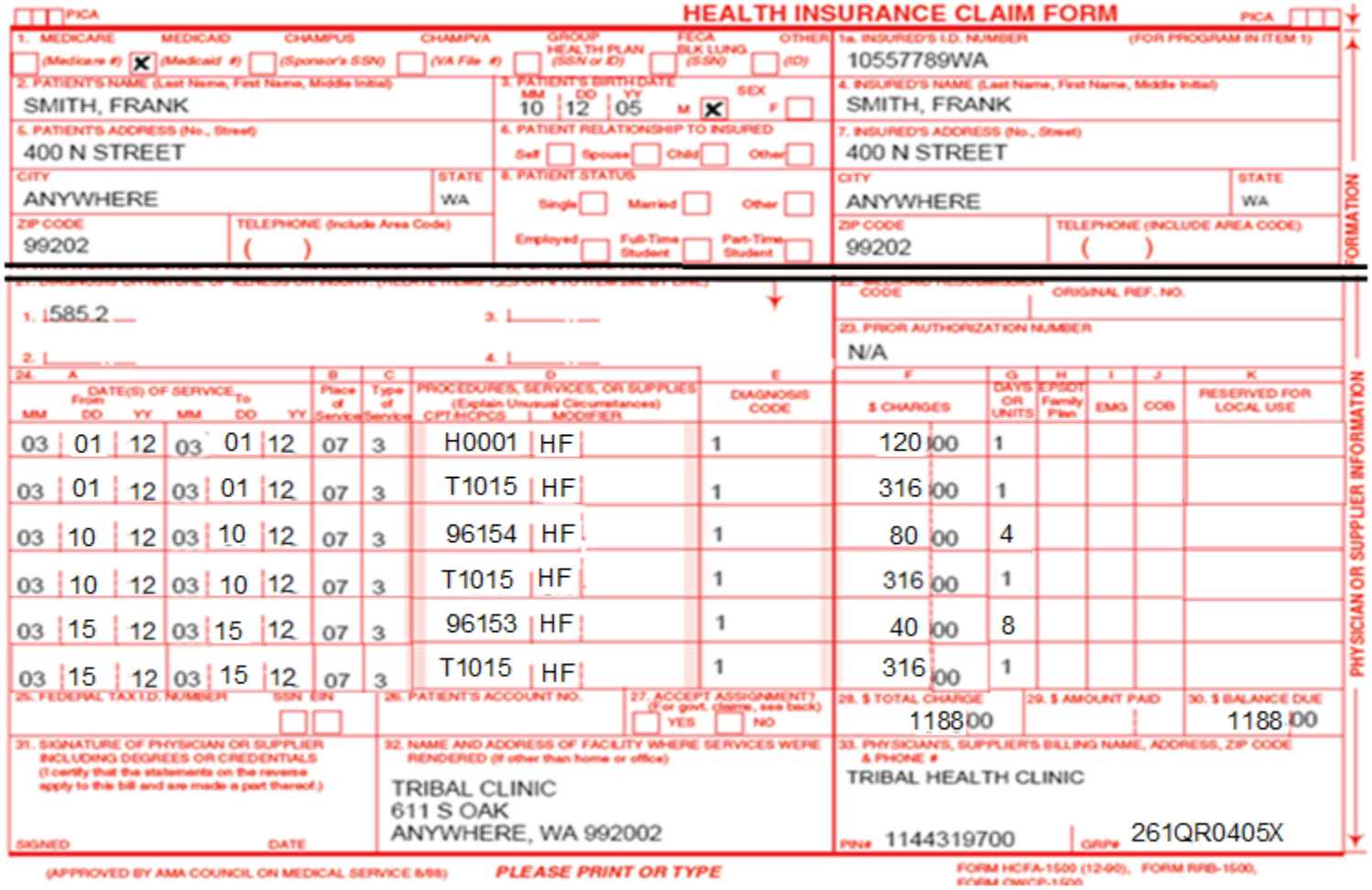
Example of a Medical Claim

How do the tribes bill for the MCO wrap around payment?

- Enter the MCO payment as if it were a commercial insurance payment.
  - ✓ Enter the same code lines that were billed to the MCO;
  - ✓ Plus the encounter line if the services billed are encounter eligible.
  - ✓ Tribal modifiers will need to be added.
  - ✓ The MCO payment data is entered at the claim level.
  - ✓ If all the MCO information is entered, add the required note "AI/AN MC tribal encounter".
  - ✓ Only claims for AI/AN tribal members qualify for the wrap around payment.
  - ✓ Payment will be up to the encounter rate.

Example of a Chemical Dependency Claim

- Illustrative example lines of a CD claim form (3 dates of service).



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6. PATIENT RELATIONSHIP TO INSURED: Self [ ] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street): 400 N STREET

CITY: ANYWHERE | STATE: WA

8. PATIENT STATUS: Single [ ] Married [ ] Other [ ]

CITY: ANYWHERE | STATE: WA

ZIP CODE: 99202 | TELEPHONE (Include Area Code): ( )

Employed [ ] Full-Time Student [ ] Part-Time Student [ ]

ZIP CODE: 99202 | TELEPHONE (INCLUDE AREA CODE): ( )

FORMATION

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY: 1. 585.2 2. 3. 4.

22. CODE | ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER: N/A

24. A DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
03	01	12	03	01	12	07	3	H0001	HF	1	120 00	1				
03	01	12	03	01	12	07	3	T1015	HF	1	316 00	1				
03	10	12	03	10	12	07	3	96154	HF	1	80 00	4				
03	10	12	03	10	12	07	3	T1015	HF	1	316 00	1				
03	15	12	03	15	12	07	3	96153	HF	1	40 00	8				
03	15	12	03	15	12	07	3	T1015	HF	1	316 00	1				

25. FEDERAL TAX I.D. NUMBER: SSN [ ] EIN [ ] | 26. PATIENT'S ACCOUNT NO. | 27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [ ] NO [ ] | 28. $ TOTAL CHARGE: 1188 00 | 29. $ AMOUNT PAID | 30. $ BALANCE DUE: 1188 00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office): TRIBAL CLINIC, 611 S OAK, ANYWHERE, WA 992002

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #: TRIBAL HEALTH CLINIC

PIN# 1144319700 | GRP# 261QR0405X

PHYSICIAN OR SUPPLIER INFORMATION

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) PLEASE PRINT OR TYPE FORM HCFA-1500 (12-90), FORM RRB-1500, FORM OWCP-1500

Example of a Chemical Dependency Claim

- How ProviderOne pays the previous slide claim example.

CD VISIT:

Procedure Codes Billed				Fee Schedule Allowed Amount
Line 1.	H0001	HF	- Chemical Dependency Assessment.....	$ 115.17
Line 2.	T1015	HF	- Tribal Encounter ($316-$115.17=$200.83)	$ 200.83
			Line 1&2 To Pay	$ 316.00
Line 3.	96154	HF	- Individual Therapy (1 hr.).....	$ 77.04
Line 4.	T1015	HF	- Tribal Encounter ($316-$77.04=$238.96)	$ 238.96
			Line 3&4 To Pay	$ 316.00
Line 5	96153	HF	- Group Therapy (2 hrs.).....	$ 38.56
Line 6.	T1015	HF	- Tribal Encounter ($316-$38.56=$277.44)	$ 277.44
			Line 5&6 To Pay	$ 316.00

Claim Fee Schedule Allowed Amount: $ 230.77

Claim Tribal Encounter Value Amount: $ 717.23

Total Claim Payment ($230.77+$717.23) $ **948.00**

Note: Line allowed amounts are for an adult from the current fee schedule.

Explanation of Payment:

In this example, the system calculates the Fee Schedule Allowed Amount for each line then subtracts that from the encounter rate and comes up with the encounter value. All 3 lines are then totaled for the final payment of 3 encounter rates or $948.00.

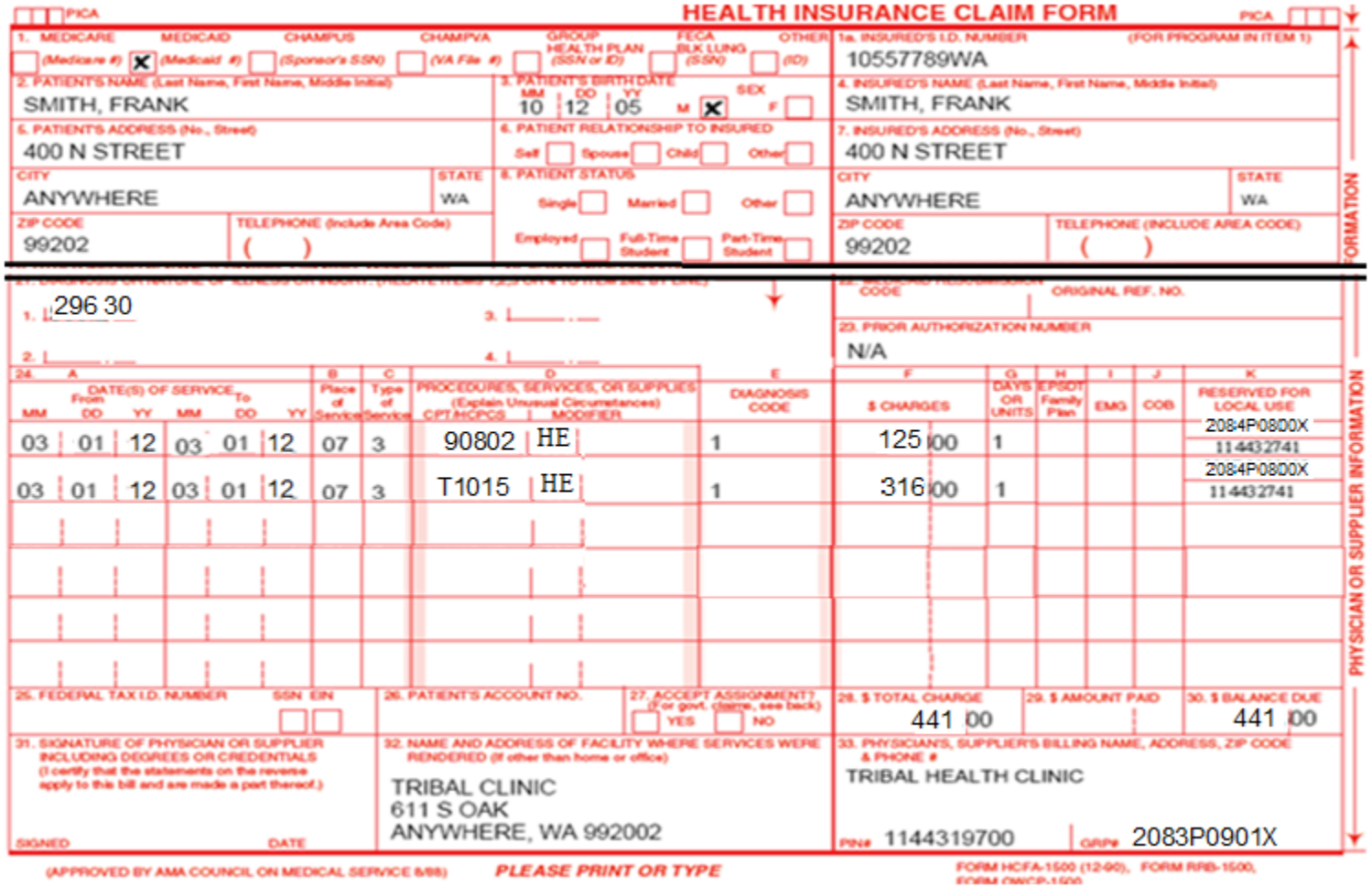
Example of a CD Claim -
How to Read the Remittance Advice

- Below is a copy of our example claim on the CD RA.
  - ✓ Each claim line shows the code and paid amount for 3 dates.
  - ✓ The Encounter lines show the paid value (in paid column).
  - ✓ Total claim payment is 3 Encounter Rates or $948.00.
  - ✓ Remember, allowed amount is not the paid amount.

TCN / Claim Type / RX Claim # / Inv # / Auth #	Line #	Rendering Provider / RX # / Auth office #	Service Date(s)	Svc Code or NDC / Mod / Rev & Class Code	Total Units or D/S	Billed Amount	Allowed Amount	Sales Tax	TPL Amount	Client Responsible Amount	Paid Amount	Remark Codes
Professional Claim	1		03/01/2012-03/01/2012	H0001 HF	1.0000	$120.00	$115.17	$0.00	$0.00	$0.00	$115.17	
Professional Claim	2		03/01/2012-03/01/2012	T1015 HF	1.0000	$316.00	$316.00	$0.00	$0.00	$0.00	$200.83	
Professional Claim	3		03/10/2012-03/10/2012	96154 HF	4.0000	$80.00	$77.04	$0.00	$0.00	$0.00	$77.04	
Professional Claim	4		03/10/2012-03/10/2012	T1015 HF	1.0000	$316.00	$316.00	$0.00	$0.00	$0.00	$238.96	
Professional Claim	5		03/12/2012-03/12/2012	96153 HF	8.0000	$40.00	$38.56	$0.00	$0.00	$0.00	$38.56	
Professional Claim	6		03/12/2012-03/12/2012	T1015 HF	1.0000	$316.00	$316.00	$0.00	$0.00	$0.00	$277.44	
		Document Total:	06/07/2011-06/28/2011		16.0000	$1188.00	$1178.77	$0.00	$0.00	$0.00	$948.00	

Example of a Mental Health Claim

- Illustrative example lines of a MH claim form.



HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE (Medicare #) X | MEDICAID (Medicaid #) | CHAMPUS (Sponsor's SSN) | CHAMPVA (VA File #) | GROUP HEALTH PLAN (SSN or ID) | FECA BLK LUNG (SSN) | OTHER (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 10557789WA

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): SMITH, FRANK

3. PATIENT'S BIRTH DATE: MM 10 DD 12 YY 05 SEX: M X F

4. INSURED'S NAME (Last Name, First Name, Middle Initial): SMITH, FRANK

5. PATIENT'S ADDRESS (No., Street): 400 N STREET

6. PATIENT RELATIONSHIP TO INSURED: Self | Spouse | Child | Other

7. INSURED'S ADDRESS (No., Street): 400 N STREET

CITY: ANYWHERE | STATE: WA

8. PATIENT STATUS: Single | Married | Other; Employed | Full-Time Student | Part-Time Student

CITY: ANYWHERE | STATE: WA

ZIP CODE: 99202 | TELEPHONE (Include Area Code): ( )

ZIP CODE: 99202 | TELEPHONE (INCLUDE AREA CODE): ( )

PHYSICIAN OR SUPPLIER INFORMATION

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY: 1. 296 30 | 2. | 3. | 4.

22. MEDICAID RESUBMISSION CODE | ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER: N/A

24. A DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
03	01	12	03	01	12	07	3	90802	HE	1	125 00	1				2084P0800X 114432741
03	01	12	03	01	12	07	3	T1015	HE	1	316 00	1				2084P0800X 114432741

25. FEDERAL TAX I.D. NUMBER: SSN | EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES | NO

28. $ TOTAL CHARGE: 441 00

29. $ AMOUNT PAID

30. $ BALANCE DUE: 441 00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office): TRIBAL CLINIC, 611 S OAK, ANYWHERE, WA 992002

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #: TRIBAL HEALTH CLINIC

PIN# 1144319700 GRP# 2083P0901X

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) PLEASE PRINT OR TYPE FORM HCFA-1500 (12-90), FORM RRB-1500, FORM CMCP-1500

Example of a Mental Health Claim

- How ProviderOne pays the previous slide claim example.

MENTAL HEALTH VISIT:

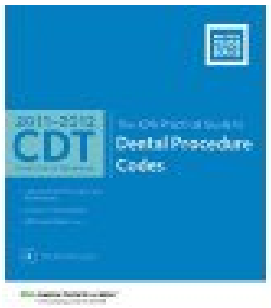
Procedure Codes Billed			Fee schedule Allowed Amount
Line 1.	90802-HE	-Diagnostic Interview Exam (Child)	$ 90.41
Line 2.	T1015 HE	-Tribal Encounter Value	$ 225.59
	Total Claim Payment	($90.41 + $225.59)	$ **316.00**

Note: Line allowed amounts are for a child from the current fee schedule.

Explanation of Payment:
In this example, the total Fee Schedule Allowed Amount is less than the T1015 Encounter Rate. ProviderOne will calculate the T1015 claim line value and pay it at Encounter Rate minus the total allowed amount for line 1 or $316.00-$90.41=$225.59. The total amount paid on the claim for all procedure codes, including the T1015 will equal the encounter rate of $316.00.

Tribal Code Billing Model - Dental

- **CDT** (Current Dental Terminology) coding claims
  - ✓ Dental claims
  - ✓ Orthodontic claims
- Plus the T1015 code for the encounter eligible services.
- The current CDT manual looks like this:



- ✓ This coding manual may be purchased at any large book store or online book store (like amazon).

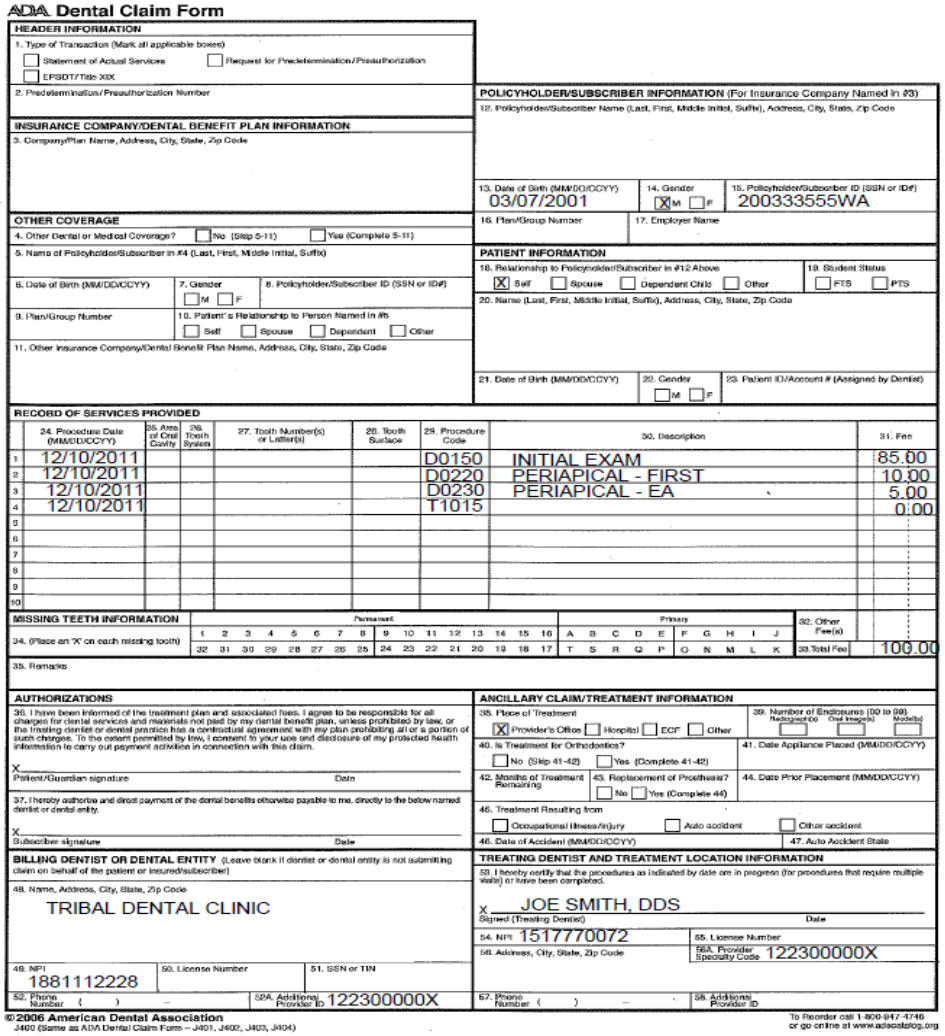
The Agency does not endorse any supplier for these products.

Tribal Code Billing Model

- Tribal Providers Billing CDT codes will bill using the:

  - ✓ DDE Dental claim form.
  - ✓ Submit electronic batch claims using the Dental claim format.
  - ✓ ADA-2006 paper claim form.

  - ✓ There is no modifier on a dental claim. Use these two new EPA numbers to indicate tribal/non-tribal clients.
    - **870001305** = Native member
    - **870001306** = Non-Native



ADA Dental Claim Form

HEADER INFORMATION

1. Type of Transaction (Mark all applicable boxes)
☐ Statement of Actual Services ☐ Request for Predetermination/Preauthorization
☐ EPSDT/Title XIX
2. Predetermination/Preauthorization Number

INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION

3. Company/Plan Name, Address, City, State, Zip Code

OTHER COVERAGE

4. Other Dental or Medical Coverage? ☐ No (Skip 5-11) ☐ Yes (Complete 5-11)
5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)
6. Date of Birth (MM/DD/CCYY) | 7. Gender ☐M ☐F | 8. Policyholder/Subscriber ID (SSN or ID#)
9. Plan/Group Number | 10. Patient's Relationship to Person Named in #5 ☐ Self ☐ Spouse ☐ Dependent ☐ Other
11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code

POLICYHOLDER/SUBSCRIBER INFORMATION (For Insurance Company Named in #3)

12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code
13. Date of Birth (MM/DD/CCYY) 03/07/2001 | 14. Gender ☒M ☐F | 15. Policyholder/Subscriber ID (SSN or ID#) 200333555WA
16. Plan/Group Number | 17. Employer Name

PATIENT INFORMATION

18. Relationship to Policyholder/Subscriber in #12 Above ☒ Self ☐ Spouse ☐ Dependent Child ☐ Other | 19. Student Status ☐ FTS ☐ PTS
20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code
21. Date of Birth (MM/DD/CCYY) | 22. Gender ☐M ☐F | 23. Patient ID/Account # (Assigned by Dentist)

RECORD OF SERVICES PROVIDED

	24. Procedure Date (MM/DD/CCYY)	25. Area of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)	28. Tooth Surface	29. Procedure Code	30. Description	31. Fee
1	12/10/2011					D0150	INITIAL EXAM	85.00
2	12/10/2011					D0220	PERIAPICAL - FIRST	10.00
3	12/10/2011					D0230	PERIAPICAL - EA	5.00
4	12/10/2011					T1015		0.00
5								
6								
7								
8								
9								
10								

MISSING TEETH INFORMATION

34. (Place an 'X' on each missing tooth) — Permanent: 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 / 32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17 — Primary: A B C D E F G H I J / T S R Q P O N M L K
32. Other Fee(s)
33. Total Fee 100.00
35. Remarks

AUTHORIZATIONS

36. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.
X Patient/Guardian signature Date
37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.
X Subscriber signature Date

ANCILLARY CLAIM/TREATMENT INFORMATION

38. Place of Treatment ☒ Provider's Office ☐ Hospital ☐ ECF ☐ Other
39. Number of Enclosures (00 to 99) Radiographs(x-rays) Oral Image(s) Model(s)
40. Is Treatment for Orthodontics? ☐ No (Skip 41-42) ☐ Yes (Complete 41-42)
41. Date Appliance Placed (MM/DD/CCYY)
42. Months of Treatment Remaining
43. Replacement of Prosthesis? ☐ No ☐ Yes (Complete 44)
44. Date Prior Placement (MM/DD/CCYY)
45. Treatment Resulting from ☐ Occupational Illness/Injury ☐ Auto accident ☐ Other accident
46. Date of Accident (MM/DD/CCYY)
47. Auto Accident State

BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber)

48. Name, Address, City, State, Zip Code: TRIBAL DENTAL CLINIC
49. NPI 1881112228 | 50. License Number | 51. SSN or TIN
52. Phone Number ( ) – | 52A. Additional Provider ID 122300000X

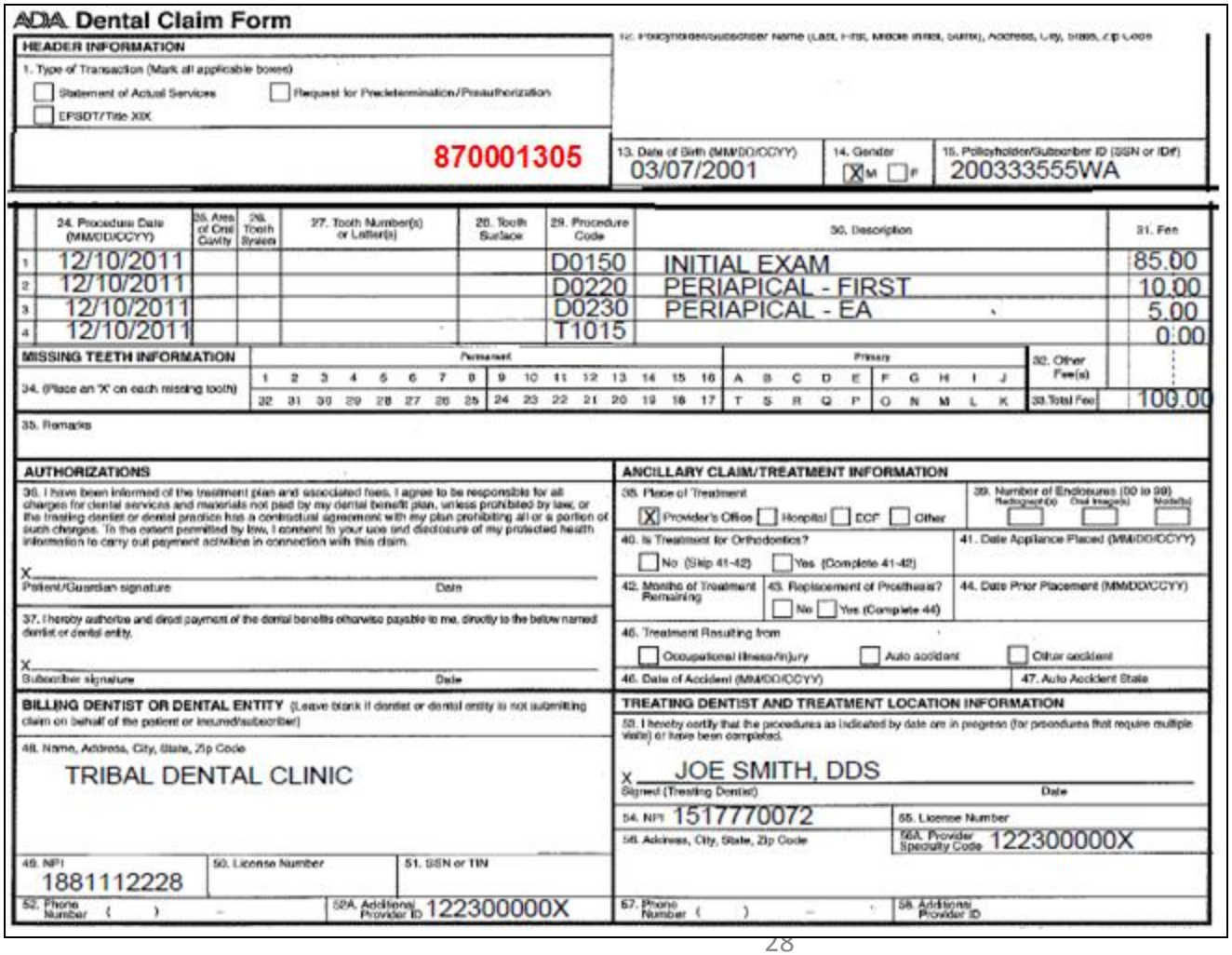
TREATING DENTIST AND TREATMENT LOCATION INFORMATION

53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed.
X JOE SMITH, DDS
Signed (Treating Dentist) Date
54. NPI 1517770072 | 55. License Number
56. Address, City, State, Zip Code | 56A. Provider Specialty Code 122300000X
57. Phone Number ( ) – | 58. Additional Provider ID

©2006 American Dental Association
J400 (Same as ADA Dental Claim Form – J401, J402, J403, J404)
To Reorder call 1-800-947-4746 or go online at www.adacatalog.org

Tribal Code Billing Model - Dental

- Illustrative example lines of a Dental claim form.



ADA Dental Claim Form

HEADER INFORMATION

1. Type of Transaction (Mark all applicable boxes)
☐ Statement of Actual Services ☐ Request for Predetermination/Preauthorization
☐ EPSDT/Title XIX

870001305

13. Date of Birth (MM/DD/CCYY) 03/07/2001 | 14. Gender ☒ M ☐ F | 15. Policyholder/Subscriber ID (SSN or ID#) 200333555WA

	24. Procedure Date (MM/DD/CCYY)	25. Area of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)	28. Tooth Surface	29. Procedure Code	30. Description	31. Fee
1	12/10/2011					D0150	INITIAL EXAM	85.00
2	12/10/2011					D0220	PERIAPICAL - FIRST	10.00
3	12/10/2011					D0230	PERIAPICAL - EA	5.00
4	12/10/2011					T1015		0.00

MISSING TEETH INFORMATION

34. (Place an 'X' on each missing tooth)

Permanent																Primary										32. Other Fee(s)	
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	A	B	C	D	E	F	G	H	I	J	33. Total Fee	100.00
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	T	S	R	Q	P	O	N	M	L	K		

35. Remarks

AUTHORIZATIONS

36. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.

X _____
Patient/Guardian signature Date

37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.

X _____
Subscriber signature Date

ANCILLARY CLAIM/TREATMENT INFORMATION

38. Place of Treatment ☒ Provider's Office ☐ Hospital ☐ ECF ☐ Other
39. Number of Enclosures (00 to 99) Radiograph(s) Oral Image(s) Model(s)
40. Is Treatment for Orthodontics? ☐ No (Skip 41-42) ☐ Yes (Complete 41-42)
41. Date Appliance Placed (MM/DD/CCYY)
42. Months of Treatment Remaining
43. Replacement of Prosthesis? ☐ No ☐ Yes (Complete 44)
44. Date Prior Placement (MM/DD/CCYY)
45. Treatment Resulting from ☐ Occupational Illness/Injury ☐ Auto accident ☐ Other accident
46. Date of Accident (MM/DD/CCYY)
47. Auto Accident State

BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber)

48. Name, Address, City, State, Zip Code
TRIBAL DENTAL CLINIC

49. NPI 1881112228
50. License Number
51. SSN or TIN
52. Phone Number ( ) -
52A. Additional Provider ID 122300000X

TREATING DENTIST AND TREATMENT LOCATION INFORMATION

53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed.

X JOE SMITH, DDS
Signed (Treating Dentist) Date

54. NPI 1517770072
55. License Number
56. Address, City, State, Zip Code
56A. Provider Specialty Code 122300000X
57. Phone Number ( ) -
58. Additional Provider ID

- Used EPA number for Tribal member (Not in field 2 on this illustration)
- Please only bill electronically!

Tribal Code Billing Model - Dental

- How ProviderOne pays the previous slide claim example.

DENTAL VISIT:

EPA Number for Native: **870001305**

Procedure Codes Billed			Fee schedule Allowed Amount
Line 1.	D0150	-Initial Exam.....	$ 33.64
Line 2.	D0220	-First Periapical X-Ray.....	$ 7.92
Line 3.	D0230	-Each additional Periapical X-Ray (1).....	$ 2.37
Total Fee Schedule Allowed Amount:			$ 43.93
Line 4.	T1015	- Tribal Encounter Value	$ 272.07
Total Claim Payment		($43.93 + $272.07)	$ **316.00**

Note: Line allowed amounts are for a child from the current fee schedule.

Explanation of Payment:

In this example, the total Fee Schedule Allowed Amount is less than the T1015 Encounter Rate. ProviderOne will calculate the T1015 claim line value and pay it at Encounter Rate minus the total allowed amount for each line or $316.00-$43.93=$272.07. The total amount paid on the claim for all procedure codes, including the T1015 will equal the encounter rate of $316.00.

Tribal Code Billing Model – Dental

How to Read the Remittance Advice

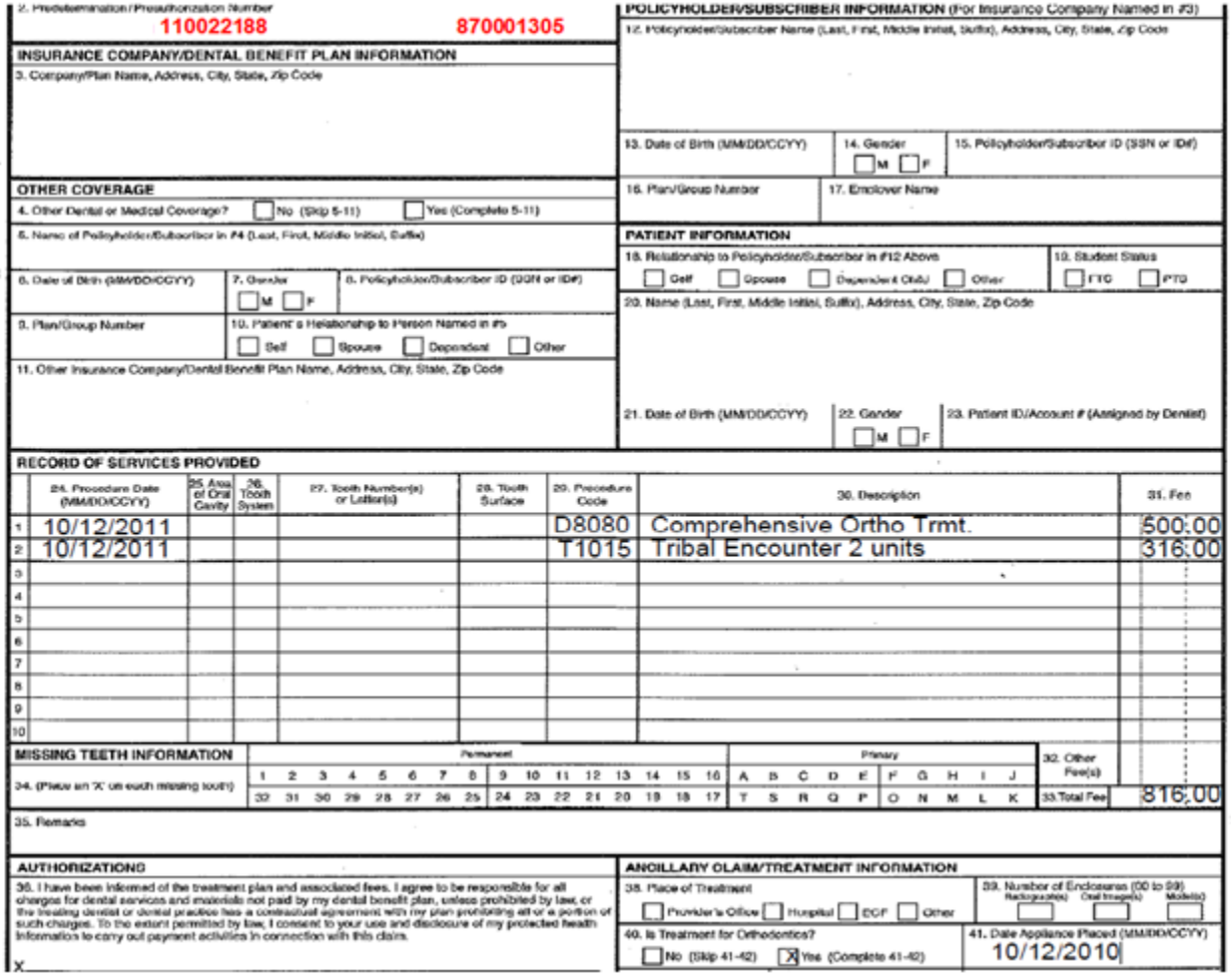
- Below is a copy of our example claim on a Dental RA.
  - ✓ Each claim line shows the code and paid amount ($43.93 total).
  - ✓ The Encounter line shows the paid value ($316.00-$43.93).
  - ✓ Total claim payment is the Encounter Rate or $316.00.

TCN / Claim Type / RX Claim # / Inv # / Auth #	Line #	Rendering Provider / RX # / Auth office #	Service Date(s)	Svc Code or NDC / Mod / Rev & Class Code	Total Units or D/S	Billed Amount	Allowed Amount	Sales Tax	TPL Amount	Client Responsible Amount	Paid Amount	Remark Codes
Dental Claim	1		08/16/2012-08/16/2012	D0150	1.0000	$105.00	$33.64	$0.00	$0.00	$0.00	$33.64	
Dental Claim	2		08/16/2012-08/16/2012	D0220	1.0000	$38.00	$7.92	$0.00	$0.00	$0.00	$7.92	
Dental Claim	3		08/16/2012-08/16/2012	D0230	1.0000	$52.00	$2.37	$0.00	$0.00	$0.00	$2.37	
Dental Claim	4		08/16/2012-08/16/2012	T1015	1.0000	$0.00	$316.00	$0.00	$0.00	$0.00	$272.07	
		Document Total:	08/16/2012-08/16/2012		4.0000	$195.00	$276.24	$0.00	$0.00	$0.00	$316.00	

Sum of Paid Amounts
$33.64
+$7.92
+$2.37
=$43.93

Tribal Code Billing Model – Ortho Dental

- Illustrative example lines of an Ortho Dental claim form.



2. Predetermination/Preauthorization Number: 110022188 870001305

INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION

3. Company/Plan Name, Address, City, State, Zip Code

POLICYHOLDER/SUBSCRIBER INFORMATION (For Insurance Company Named in #3)

12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

13. Date of Birth (MM/DD/CCYY) | 14. Gender ☐M ☐F | 15. Policyholder/Subscriber ID (SSN or ID#)

16. Plan/Group Number | 17. Employer Name

OTHER COVERAGE

4. Other Dental or Medical Coverage? ☐No (Skip 5-11) ☐Yes (Complete 5-11)

5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)

6. Date of Birth (MM/DD/CCYY) | 7. Gender ☐M ☐F | 8. Policyholder/Subscriber ID (SSN or ID#)

9. Plan/Group Number | 10. Patient's Relationship to Person Named in #5 ☐Self ☐Spouse ☐Dependent ☐Other

11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code

PATIENT INFORMATION

18. Relationship to Policyholder/Subscriber in #12 Above ☐Self ☐Spouse ☐Dependent Child ☐Other | 19. Student Status ☐FTS ☐PTS

20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

21. Date of Birth (MM/DD/CCYY) | 22. Gender ☐M ☐F | 23. Patient ID/Account # (Assigned by Dentist)

RECORD OF SERVICES PROVIDED

	24. Procedure Date (MM/DD/CCYY)	25. Area of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)	28. Tooth Surface	29. Procedure Code	30. Description	31. Fee
1	10/12/2011					D8080	Comprehensive Ortho Trmt.	500.00
2	10/12/2011					T1015	Tribal Encounter 2 units	316.00
3								
4								
5								
6								
7								
8								
9								
10								

MISSING TEETH INFORMATION

24. (Place an 'X' on each missing tooth)

Permanent: 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 / 32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17

Primary: A B C D E F G H I J / T S R Q P O N M L K

32. Other Fee(s)

33. Total Fee: 816.00

35. Remarks

AUTHORIZATIONS

36. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.

X

ANCILLARY CLAIM/TREATMENT INFORMATION

38. Place of Treatment ☐Provider's Office ☐Hospital ☐ECF ☐Other

39. Number of Enclosures (00 to 99) Radiographs(s) Oral Image(s) Model(s)

40. Is Treatment for Orthodontics? ☐No (Skip 41-42) ☒Yes (Complete 41-42)

41. Date Appliance Placed (MM/DD/CCYY) 10/12/2010

There would be two authorization numbers on an Ortho claim:

- ✓ One is for authorization for the Ortho services.
- ✓ The other EPA number is to indicate if a tribal or non-tribal member.
- ✓ An Ortho auth. and EPA have been added to this example claim.

Tribal Code Billing Model – Ortho Dental

- How ProviderOne pays the previous slide claim example.

ORTHO DENTAL VISIT:

Ortho Authorization **110022188**
EPA Number for Native: **870001305**

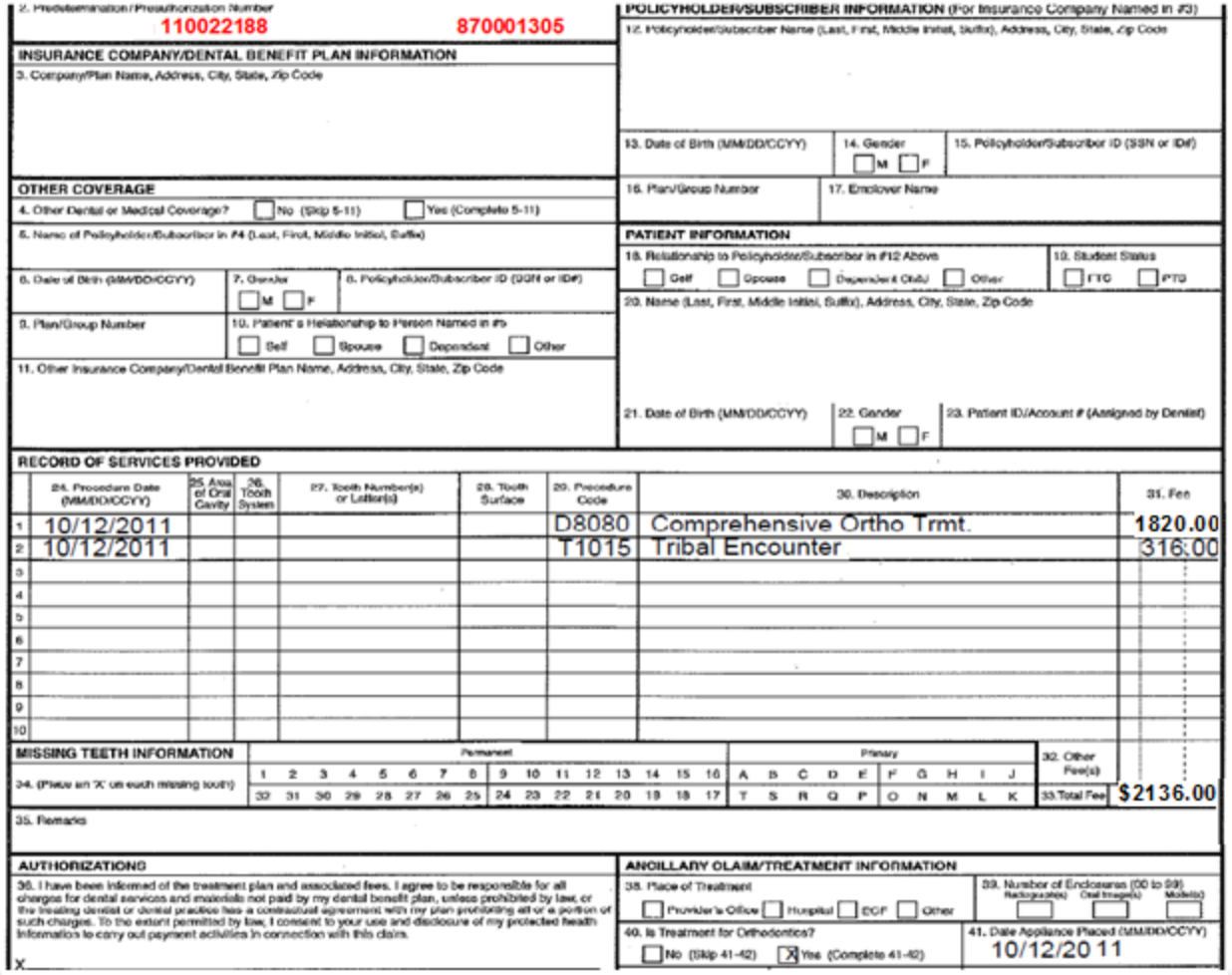
Procedure Codes Billed		Fee schedule Allowed Amount
Line 1.	D8080 -Comprehensive Ortho Trmt. 3-Month....	$ 308.46
Total Fee Schedule Allowed Amount:		$ 308.46
Line 2.	T1015 -Tribal Encounter Value (2 units)	$ 323.54
	Total Claim Payment ($308.46 + $323.54)	$ **632.00**

Note: Line allowed amounts are for a child from the current fee schedule.

Explanation of Payment:
In this example, the total Fee Schedule Allowed Amount is less than the program allowed 2 units for the T1015 Encounter Rate. ProviderOne will calculate the T1015 claim line value and pay it at 2 Encounter unit Rate minus the total allowed amount for each line or $632.00-$308.46=$323.54. The total amount paid on the claim for all procedure codes, including the 2 units of T1015 will equal 2 encounter rates or $632.00.

Tribal Code Billing Model – Ortho Dental

- Illustrative example lines of an Ortho Banding Dental claim form.



2. Predetermination / Preauthorization Number: 110022188 870001305

INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION

3. Company/Plan Name, Address, City, State, Zip Code

POLICYHOLDER/SUBSCRIBER INFORMATION (For Insurance Company Named in #3)

12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

13. Date of Birth (MM/DD/CCYY) | 14. Gender ☐ M ☐ F | 15. Policyholder/Subscriber ID (SSN or ID#)

16. Plan/Group Number | 17. Employer Name

OTHER COVERAGE

4. Other Dental or Medical Coverage? ☐ No (Skip 5-11) ☐ Yes (Complete 5-11)

5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)

6. Date of Birth (MM/DD/CCYY) | 7. Gender ☐ M ☐ F | 8. Policyholder/Subscriber ID (SSN or ID#)

9. Plan/Group Number | 10. Patient's Relationship to Person Named in #5 ☐ Self ☐ Spouse ☐ Dependent ☐ Other

11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code

PATIENT INFORMATION

18. Relationship to Policyholder/Subscriber in #12 Above ☐ Self ☐ Spouse ☐ Dependent Child ☐ Other | 19. Student Status ☐ FTS ☐ PTS

20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

21. Date of Birth (MM/DD/CCYY) | 22. Gender ☐ M ☐ F | 23. Patient ID/Account # (Assigned by Dentist)

RECORD OF SERVICES PROVIDED

	24. Procedure Date (MM/DD/CCYY)	25. Area of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)	28. Tooth Surface	29. Procedure Code	30. Description	31. Fee
1	10/12/2011					D8080	Comprehensive Ortho Trmt.	1820.00
2	10/12/2011					T1015	Tribal Encounter	316.00
3								
4								
5								
6								
7								
8								
9								
10								

MISSING TEETH INFORMATION

34. (Place an 'X' on each missing tooth)

Permanent																Primary										32. Other Fee(s)	
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	A	B	C	D	E	F	G	H	I	J	33. Total Fee	$2136.00
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	T	S	R	Q	P	O	N	M	L	K		

35. Remarks

AUTHORIZATIONS

36. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.

X

ANCILLARY CLAIM/TREATMENT INFORMATION

38. Place of Treatment ☐ Provider's Office ☐ Hospital ☐ ECF ☐ Other

39. Number of Enclosures (00 to 99) Radiographs(s) | Oral Image(s) | Model(s)

40. Is Treatment for Orthodontics? ☐ No (Skip 41-42) ☒ Yes (Complete 41-42)

41. Date Appliance Placed (MM/DD/CCYY) 10/12/2011

There would be two authorization numbers on an Ortho claim:

- ✓ One is for authorization for the Ortho services.
- ✓ The other EPA number is to indicate if a tribal or non-tribal member.

Tribal Code Billing Model – Ortho Dental

- How ProviderOne pays the previous slide claim example.

ORTHO DENTAL VISIT BANDING:

Ortho Authorization **110022188**
EPA Number for Native: **870001305**

Procedure Codes Billed			Fee schedule Allowed Amount
Line 1.	D8080	-Comprehensive Ortho Trmt. Banding...	$ 1820.00
Total Fee Schedule Allowed Amount:			$ 1820.00
Line 2.	T1015	-Tribal Encounter Value.....	$ -1504.00
	Total Claim Payment	($1820.00 + (-$1504.00)	$ **316.00**

Note: Line allowed amounts are for illustration only. See the current fee schedule for updated rates.

Explanation of Payment:
In this example, the total Fee Schedule Allowed Amount is more than the program allowed unit for the T1015 Encounter Rate initially for banding. ProviderOne will calculate the T1015 claim line value and pay it at Encounter unit Rate minus the total allowed amount for the code line or $316.00-$1820.00=$-1504.00. The total amount paid on the claim for the procedure, including the T1015 will equal 1 encounter rate or $316.00. **Remember to adjust this claim after 6 months to the 5 encounter units allowable.**

Tribal Code Billing Model – Ortho Dental

How to Read the Remittance Advice

- Below is a copy of our example claim the Ortho Dental RA.
  - ✓ The claim line shows the code and paid amount ($1820.00).
  - ✓ The Encounter line shows the paid value ($316.00-$1820.00=$-1504.00)).
  - ✓ Total claim payment is the Encounter Rate or $316.00
  - ✓ This claim example shows an encounter value could be a negative number.

TCN / Claim Type / RX Claim # / Inv # / Auth #	Line #	Rendering Provider / RX # / Auth office #	Service Date(s)	Svc Code or NDC / Mod / Rev & Class Code	Total Units or D/S	Billed Amount	Allowed Amount	Sales Tax	TPL Amount	Client Responsible Amount	Paid Amount	Remark Codes
201206700022618000 Dental Claim	1		10/12/2011-10/12/2011	D8080	1.0000	$1820.00	$1820.00	$0.00	$0.00	$0.00	$1820.00	
201206700022618000 Dental Claim	2		10/12/2011-10/12/2011	T1015	1.0000	$316.00	$316.00	$0.00	$0.00	$0.00	-$1504.00	
Document Total:			10/12/2011-10/12/2011		2.0000	$2136.00	$2136.00	$	$0.00	$0.00	$316.00	

Note: Ortho Providers can adjust this claim after 6 months to get paid a true banding rate (5 encounter units).

Tribal Code Billing Model – Billing Taxonomy Codes

- The following list of Taxonomy Codes are used by the tribal billing NPI number to identify service types:

Program	Billing Facility Taxonomy
Substance Abuse	261QR0405X
Dental	122300000X
Mental Health	2083P0901X
Medical	208D00000X
Psychiatric	2084P0800X

- Claims for encounters must have on of these taxonomies billed on the claim for the billing NPI.
- Other programs may have their specialized taxonomy i.e. Physical Therapy, Maternity Support Services, etc.
- If these services are offered by the clinic, the taxonomy codes should already be listed on the billing provider file.

Tribal Code Billing Model – How to find Taxonomy Codes in ProviderOne

- To find each rendering provider taxonomy codes:
  - ✓ Log into ProviderOne
  - ✓ Use one of the billing profiles or super user to view the billing provider file
  - ✓ On the Portal page scroll down a click on Manage Provider Information
  - ✓ Click on Step 15, Servicing Provider list page
  - ✓ At the list of rendering providers find the provider of interest
  - ✓ Click on their name to hyperlink to their provider file
  - ✓ At the provider's file, click on specializations to see their list of taxonomy codes

Tribal Code Billing Model –
How to find Taxonomy Codes in ProviderOne

- ProviderOne lists Taxonomy codes in separate segments:

Provider Type	Specialty/Subspecialty	Administration	Start Date	End Date	Operational Status
20-Allopathic & Osteopathic Physicians	8D-General Practice/00000-General Practice	HRSA	01/25/2010	12/31/2999	Active

- ✓ The first column describes the provider type: **20**
- ✓ The second column describes the specialty and subspecialty of the provider type: **8D00000**
- ✓ ProviderOne does not display the last character "**X**"
- ✓ The taxonomy code for the provider in this example is: **208D00000X**
- ✓ Providers may have more than one taxonomy on their file
- ✓ Use the taxonomy appropriate for the service being billed

Tribal Code Billing Model – Program and Service Limits

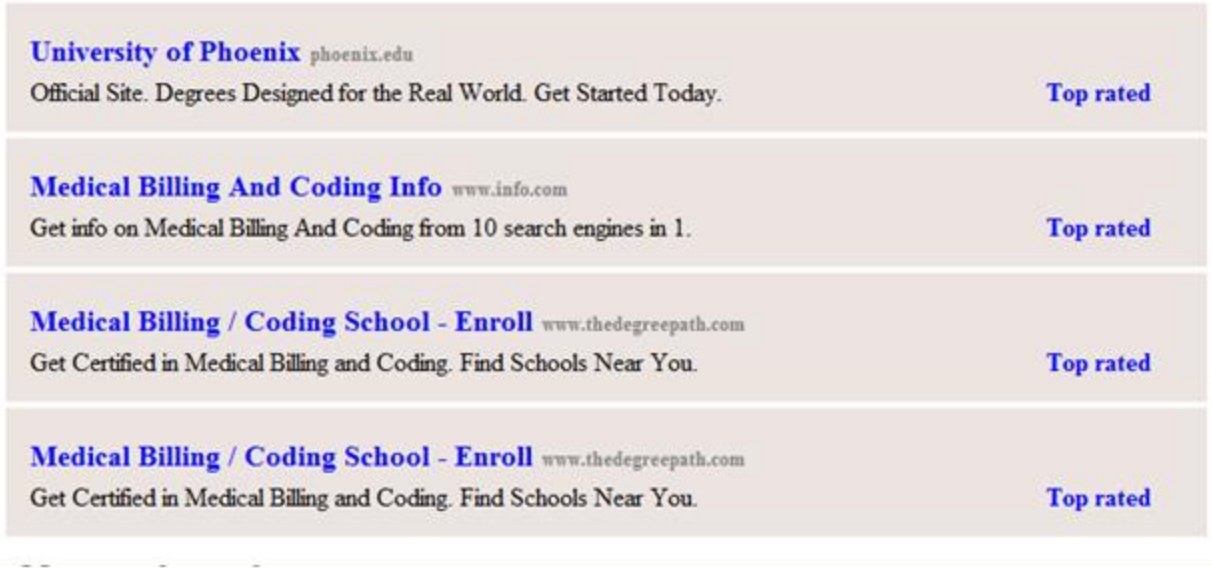
- Each specific program may have Service Limits.
  - ✓ Use of codes could trigger system edits for service limits.
    - Adults may have limits on their services (PT, OT, etc.).
      - (I.E.) Psych limit is 12 visits per year for adults.
    - Children usually have more liberal service limits.
      - (I.E.)Psych limit is 20 visits per year for children.
  - ✓ Program services may require specific program modifiers in addition to tribal modifiers.
  - ✓ Some program services require specific ICD-9 diagnosis codes.
  - ✓ Procedure codes and diagnosis codes must be compatible.

Tribal Code Billing Model – Program and Service Limits

- Each specific program may have Service Limits.
  - ✓ Each specific program has their own Medicaid Provider Guides in addition to the Tribal Provider Guide.
  - ✓ Specific program limits, modifiers, and specific ICD-9 diagnosis codes can be found in those Provider Guides.
  - ✓ Provider Guides are located at http://hrsa.dshs.wa.gov/Download/BI.html

Tribal Code Billing Model – Additional Training Resources

- There is additional coding/billing training available online:
  - ✓ Google to find Certified Coding Training.

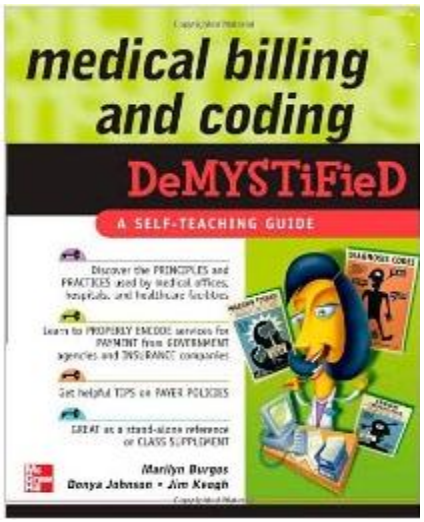


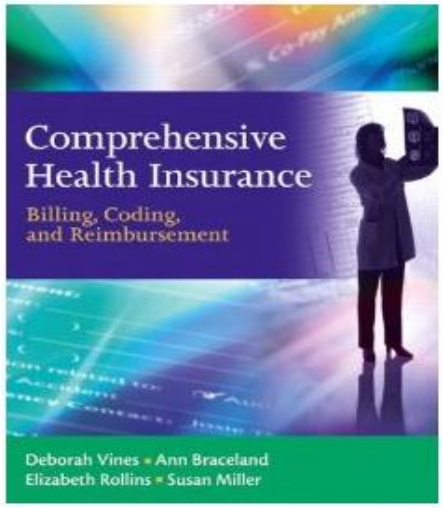
  - ✓ Instate colleges may have online training also.

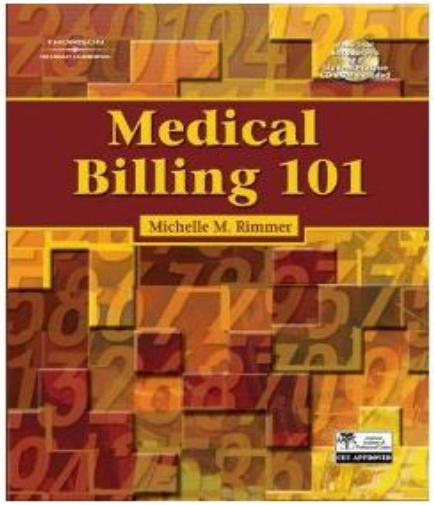
Note: The Agency does not endorse any Coding Training school/course.

Tribal Code Billing Model – Additional Training Resources

- There is additional coding/billing training available online:
  - ✓ How about just a reference Manual?



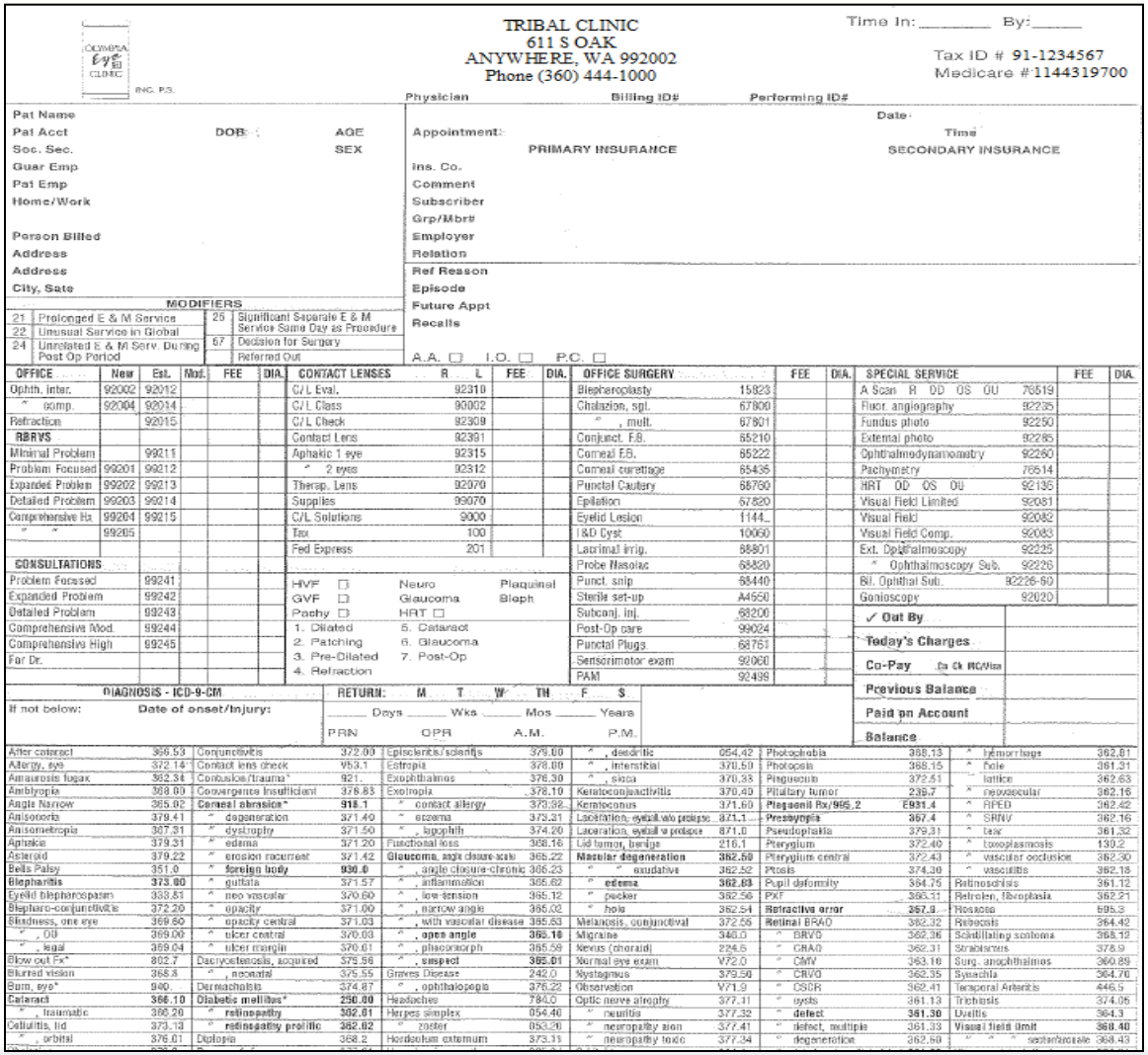




  - ✓ Many reference books are available.

Note: The Agency does not endorse any commercial reference manual.

Tribal Code Billing Model –
Standard Medical Coding Aid Form



TRIBAL CLINIC
611 S OAK
ANYWHERE, WA 992002
Phone (360) 444-1000

Time In: _____ By: _____

Tax ID # 91-1234567
Medicare #1144319700

Physician | Billing ID# | Performing ID#

Pat Name | Pat Acct | Soc. Sec. | Guar Emp | Pat Emp | Home/Work | Person Billed | Address | Address | City, State | DOB | AGE | SEX

Appointment: | Date | Time

PRIMARY INSURANCE | SECONDARY INSURANCE

Ins. Co. | Comment | Subscriber | Grp/Mbr# | Employer | Relation | Ref Reason | Episode | Future Appt | Recalls

A.A. ☐ I.O. ☐ P.C. ☐

MODIFIERS

21	Prolonged E & M Service	25	Significant Separate E & M Service Same Day as Procedure
22	Unusual Service in Global	57	Decision for Surgery
24	Unrelated E & M Serv. During Post Op Period		Referred Out

OFFICE	New	Est.	Mod.	FEE	DIA.
Ophth. Inter.	99002	92012			
" comp.	99004	92014			
Refraction		92015			
RBRVS					
Minimal Problem		99211			
Problem Focused	99201	99212			
Expanded Problem	99202	99213			
Detailed Problem	99203	99214			
Comprehensive Hi	99204	99215			
" "	99205				
CONSULTATIONS					
Problem Focused		99241			
Expanded Problem		99242			
Detailed Problem		99243			
Comprehensive Mod.		99244			
Comprehensive High		99245			
For Dr.					

CONTACT LENSES	R	L	FEE	DIA.
C/L Eval.		92310		
C/L Glass		90002		
C/L Check		92309		
Contact Lens		92391		
Aphakic 1 eye		92315		
" 2 eyes		92312		
Therap. Lens		92070		
Supplies		99070		
C/L Solutions		9000		
Tax		100		
Fed Express		201		

HVF ☐ Neuro Plaquinel
GVF ☐ Glaucoma Bleph
Pachy ☐ HRT ☐

1. Dilated 5. Cataract
2. Patching 6. Glaucoma
3. Pre-Dilated 7. Post-Op
4. Refraction

OFFICE SURGERY		FEE	DIA.
Blepharoplasty	15823		
Chalazion, spl.	67800		
" , mult.	67801		
Conjunct. F.B.	65210		
Corneal F.B.	65222		
Corneal curettage	65435		
Punctal Cautery	68760		
Epilation	67820		
Eyelid Lesion	1144_		
I&D Cyst	10060		
Lacrimal irrig.	68801		
Probe Nasolac	68820		
Punct. snip	68440		
Sterile set-up	A4550		
Subconj. inj.	68200		
Post-Op care	99024		
Punctal Plugs	68761		
Sensorimotor exam	92060		
PAM	92499		

SPECIAL SERVICE		FEE	DIA.
A Scan R OD OS OU	76519		
Fluor. angiography	92235		
Fundus photo	92250		
External photo	92285		
Ophthalmodynamometry	92260		
Pachymetry	76514		
HRT OD OS OU	92135		
Visual Field Limited	92081		
Visual Field	92082		
Visual Field Comp.	92083		
Ext. Ophthalmoscopy	92225		
" Ophthalmoscopy Sub.	92226		
Bil. Ophthal Sub.	92226-50		
Gonioscopy	92020		

✓ Out By
Today's Charges
Co-Pay Ca Ck MC/Visa
Previous Balance
Paid on Account
Balance

DIAGNOSIS - ICD-9-CM

If not below: Date of onset/injury:

RETURN: M T W TH F S
_____ Days _____ Wks _____ Mos _____ Years
PRN OPR A.M. P.M.

After cataract	366.53	Conjunctivitis	372.00	Episcleritis/scleritis	379.00	" , disciriitis	054.42	Photophobia	368.13	" hemorrhage	362.81
Allergy, eye	372.14*	Contact lens check	V53.1	Estropia	378.00	" , interstitial	370.59	Photopsia	368.15	" hole	361.31
Amaurosis fugax	362.34	Contusion/trauma*	921.	Exophthalmos	376.30	" , sicca	370.33	Pinguecula	372.51	" lattice	362.63
Amblyopia	368.00	Convergence insufficient	378.83	Exotropia	378.10	Keratoconjunctivitis	370.49	Pituitary tumor	239.7	" neovascular	362.16
Angle Narrow	365.02	**Corneal abrasion***	**918.1**	" contact allergy	370.32	Keratoconus	371.60	**Plaquenil Rx/965.2**	**E931.4**	" RPED	362.42
Anisocoria	379.41	" degeneration	371.40	" eczema	373.31	Laceration, eyelid w/o prolapse	871.1	**Presbyopia**	**367.4**	" SRNV	362.16
Anisometropia	367.31	" dystrophy	371.50	" , lipophth	374.20	Laceration, eyelid w prolapse	871.0	Pseudophakia	379.31	" tear	361.32
Aphakia	379.31	" edema	371.20	Functional loss	368.16	Lid tumor, benign	216.1	Pterygium	372.40	" toxoplasmosis	130.2
Asteroid	379.22	" erosion recurrent	371.42	**Glaucoma**, angle closure-acute	365.22	**Macular degeneration**	**362.50**	Pterygium central	372.43	" vascular occlusion	362.30
Bells Palsy	351.0	" **foreign body**	**930.0**	" , angle closure-chronic	366.23	" " exudative	362.52	Ptosis	374.30	" vasculitis	362.18
Blepharitis	**373.00**	" guttata	371.57	" , inflammation	365.62	" **edema**	**362.83**	Pupil deformity	364.75	Retinoschisis	361.12
Eyelid blepharospasm	333.81	" neo vascular	370.60	" , low tension	365.12	" pucker	362.56	PXF	365.31	Retrolen, fibroplasia	362.21
Blepharo-conjunctivitis	372.20	" opacity	371.00	" , narrow angle	365.02	" hole	362.54	**Refractive error**	**367.9**	Rosacea	695.3
Blindness, one eye	369.60	" opacity central	371.03	" , with vascular disease	365.63	Melanosis, conjunctival	372.55	**Retinal BRAO**	362.32	Rubeosis	364.42
" , OU	369.00	" ulcer central	370.03	" , **open angle**	**365.10**	Migraine	346.0	" BRVO	362.36	Scintillating scotoma	368.12
" , legal	369.04	" ulcer marginl	370.01	" , pheomorph	365.59	Nevus (choroid)	224.6	" CRAO	362.31	Strabismus	378.9
Blow out Fx*	802.7	Dacryocystocele, acquired	375.56	" , **suspect**	**365.01**	Normal eye exam	V72.0	" CMV	363.10	Surg. anophthalmos	360.89
Blurred vision	368.8	" , neonatal	375.55	Graves Disease	242.0	Nystagmus	379.50	" CRVO	362.35	Synechia	364.70
Burn, eye*	940.	Dermacholsis	374.87	" , ophthalopepia	376.22	Observation	V71.9	" CSDR	362.41	Temporal Arteritis	446.5
Cataract	**366.10**	**Diabetic mellitus***	**250.00**	Headaches	784.0	Optic nerve atrophy	377.11	" cysts	361.13	Trichiasis	374.05
" , traumatic	366.20	" **retinopathy**	**362.01**	Herpes simplex	054.40	" neuritis	377.32	" **defect**	**361.30**	Uveitis	364.3
Cellulitis, lid	373.13	" **retinopathy prolific**	**362.02**	" zoster	053.20	" neuropathy ajon	377.41	" defect, multiple	361.33	**Visual field limit**	**368.40**
" , orbital	376.01	Diplopia	368.2	Hordeolum externum	373.11	" neuropathy toxic	377.34	" degenerative	362.60	" " sectar/arcuate	368.43

- Copy of a document called a "Superbill."
- Online Google "Superbill" to find free downloads.
- Superbills may be purchased at office supply stores.

Washington State Health Care Authority

Tribal Code Billing Model – Standard Medical Coding Aid Form

- The "Superbill" is pre-coded with common services done during an office visit including:
  - ✓ Office visit codes.
  - ✓ ICD-9 diagnosis codes.
  - ✓ Special Service codes that could be commonly provided (lab, x-ray).
- Use of the "Superbill" is easy for a busy practice or large clinic.
  - ✓ Provider performing the service simply circles the procedure code of the service done at the end of the visit.
  - ✓ Provider would also circle the diagnosis code they determined caused the reason for the visit (or indicates one if not pre-printed).
  - ✓ Provider would also circle any lab tests ordered (or indicates one if not pre-printed).
- The billers then easily generate a claim from the "Superbill".

Other Training Options

- Training web page at http://hrsa.dshs.wa.gov/provider/training.shtml

General Billing Information

ProviderOne Billing and Resource Guide

This Guide:

- Provides general information that applies to most Medicaid providers.
- Takes providers through the process for billing the Medicaid Program of the Health Care Authority for covered services delivered to eligible clients.

- Find the Guide at http://hrsa.dshs.wa.gov/download/ProviderOne_Billing_and_Resource_Guide.html

References

General Information about Medicaid:

- Summarized in the ProviderOne Billing and Resource Guide http://hrsa.dshs.wa.gov/download/ProviderOne_Billing_and_Resource_Guide.html.
- See the Provider Training web site for links to recorded Webinars, E-Learning, and Manuals http://www.dshs.wa.gov/provider/training.shtml.
- Find the Tribal Medicaid Provider Guide (formerly the billing instructions) at http://hrsa.dshs.wa.gov/Download/BI.html.

QUESTIONS